Personal Assistance Oversight Minutes
Wednesday, June 20, 2018 1:00 – 3:00 (MDT) 12:00 -2:00 (PDT)

Welcome and Roll Call	Alexandra Fernández Bureau Chief	Action: • Members participating via phone: Jacob Massey, Jan Carpenter, Guests: Sheri Massey and Mitzi Lewis • Members participating via video: Medicaid Staff: Melanie Belnap and Chris Barrott • Members at the Elder location: Pam Ziegenfuss and Sharon Anitok • Medicaid Staff at the Elder location: Ali Fernández, Marcie Young, Katie Davis, Tammy Ray, Mandi Hanifen, Alex Childers-Scott, Jennifer Pinkerton • Members excused: Dana Gover, Kevin Thorson, Karen Raine, Judy Taylor, Zachary Harris • Members Absent: Brett Waters, Tracy Martin, Marcy Hayman, Linda Weisse
OLD BUSINESS		
Read, Review and Approve DRAFT Minutes from March 21, 20108 (Attachment)	Alexandra Fernández Bureau Chief	Action: • Motion to approve the DRAFT Minutes from the March 31, 2018 meeting was made by Sharon Anitok and seconded by Pam Ziegenfuss • Approved minutes from the March 21, 2018 meeting will be posted on the H&W Website at PAO Minutes March 21, 2018
PLANNING		
PAO Committee Composition	Alexandra Fernández Bureau Chief	Action: • We have some member terms that have expired, these members were contacted to see if they were interested in continuing to serve • Dana Gover – participant Central HUB - term expired on 4/1/2018 We received a nomination form from Dana. Ali read her nomination, Sharon Anitok made the motion to accept Dana's nomination and Pam Ziegenfuss seconded • Karen Raine – provider Central HUB term expired on 4/1/2018 Thank you, Karen, for your service and support! • Dean Neilson – provider Eastern Hub term expired on 4/1/2018 Thank you, Dean, for your years of service and support! • Judy Taylor –ICOA – Agency Advocate – term expired on 6/17/2018 Thank you, Judy for your service and support! • As of 6-20-2018 we have 7 vacancies: • 1) Participant Statewide (Any HUB) • 1) Participant from the Central HUB • 2) Participant from the Eastern HUB • 1) Provider Central HUB • 1) Provider Eastern HUB • 1) Advocate (this position has historically been held by a representative from an advocacy agency/organization that is involved with our participants and their services)

		• PAO Minutes 6-20-2018If you know of a person that would be interested in serving in any of these positions – Please talk to them and use the "Join Here" button on the DHW website at http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCareAdvisoryCommittee/PersonalAssistanceOversightCommittee/tabid/1354/Default.aspx
MONITORING		
BFO/ Cost Surveys (Attachment)	Cale Coyle Bureau of Financial Operations Program Manager	Action: • This PowerPoint and information was developed at the request of the PAO Committee • Cale Coyle presented the PowerPoint: "The Life of a Cost Survey and Reimbursement From Inception to Pocket": • What is a Cost Survey? • What types of costs are to be reported • Cost Per Unit • Determine the Rate • For additional questions, contact Tammy Martin with Myers & Stauffer, the accounting contractor for the Division of Medicaid at: Tammym@mslc.com
Electronic Visit Verification Presentation (Attachment)	Alexandra Fernández Bureau Chief	Action: • This PowerPoint and information was developed at the request of the PAO Committee • Electronic Visit Verification (EVV) Overview of Regulations and Idaho's Implementation Plan • Alexandra gave the background of the EVV mandate which was part of the 21st Century CURES ACT, Section 12006 gives the dates by which the states are to implement an EVV system • Financial penalties for non-compliance will be imposed on the state not on providers • EVV Requirements and the information that the system must capture • Implementation Options, Challenges and Opportunities • Lessons learned from other states: 1) Start with an analysis of service definitions and identify scope 2) Conduct environmental scan, Current provider EVV adoption should play a role in our next steps 3) Thoughtful implementation is better than rapid implementation • Idaho's Implementation Plan: 1) Summer 2018 – Start Stakeholder workgroups 2) Spring 2019 – Begin rulemaking process 3) Summer 2020 – Rules go into effect and program goes live • Progress information will be sent to the PAO members and we will add it as a standing agenda item
Quality Assurance 1st Quarter 2018 Reports (Attachment)	Chris Barrott BLTC QA Manager	Action: • Overview of Q1 Bureau of Long Term Care Quality Improvement Strategy reports • Recently held a Spring Provider Summit – 2 days of Webinars and had over 300 Providers logged in. QA training was well received by providers. We held trainings for PAAs, CFHs, and RALFs separately to address each providers type's unique situations.

		• Page 1 94% of applicants for the A&D Waiver are meeting the Level of Care Assessment - we expect this rise in numbers to continue with the growth in Idaho • Page 4 Due to staff shortages only 89% of Annual Assessments are meeting the timelines (364 days) – to remediate this issue, Nurses from other regions have assisted and all are working together to ensure that timelines are completed on time • Page 8 Recently held a Spring Provider Summit – 2 days of Webinars with 300 Providers logged in. QA online training has been well received by providers. • Each year in August the National Association of States United for Aging and Disabilities (NASUAD) holds a Home and Community Base Services (HCBS) conference that is attended by 15,000 people nationwide. This year Ali, Chris and 2 of our providers were accepted to present at the conference and the title of their presentation is "Help Me Help You" a Partnership With Quality Audits. A lot of presentations are submitted each year and to be chosen, indicates the value of our new training/auditing/reporting and provider relationships • If you have any question about this report, contact Chris Barrott, BLTC QA Manager at Chris.Barrott@dhw.idaho.gov or (208)732-1482
Idaho Home Choice (IHC) Update (Attachment)	Tammy Ray IHC Project Manager	Action: • IHC Program has completed 521 Transitions to date • IHC Benchmark for CY 2018 is 87 Transitions - they have completed 27 • IHC has received budget for this year • Currently working on IHC sustainability after the demonstration has closed • Transition Manager services will be State Plan and other services will be added to the A&D and DD Waivers • Negotiated Rulemaking meeting was held in Boise last Thursday, 6/14/18 and Public Hearings will be held in Lewiston and Idaho Falls on Tuesday, 9/11/18 and in Boise on Thursday, 9/13/18 • Additional IHC Information is available at: http://healthandwelfare.idaho.gov/Medical/Medicaid/IdahoHomeChoice/tabid/1621/Default.aspx
Medicare Medicaid Coordinated Plan (MMCP) Update	Mandi Hanifen MMCP Contract Monitor	Action: • MMCP enrollment growing strong. • Total enrollment of both plans 3565 members • MMCP is voluntary • Members can choose between two plans in 9 counties • Mandi is working on a public-facing dash board that will compare quality data of the two plans
Idaho Medicaid Plus (Attachment)	Alexandra Fernández Bureau Chief Chris Barrott	Action: • Idaho Medicaid Dual Eligible Program Options FAQs • https://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidParticipants/Medicare-MedicaidCoordinatedPlan/tabid/2538/Default.aspx

	Medicaid Program Policy Analyst	• Ali provided an overview of the new mandatory managed care program for Duals called "Idaho Medicaid Plus" and reviewed the FAQs (link above).
		• Key points:
		  • Idaho Medicaid Plus will administer only a person's Medicaid benefits. Medicare coverage is not affected.
		  • It will be mandatory in counties where Molina Healthcare and Blue Cross of Idaho operate. That means duals who haven't signed up for the MMCP and who aren't in an excluded group (see FAQs) will have to choose one of the health plans to manage their Medicaid benefits.
		  • Idaho Medicaid Plus is going live in Twin Falls County as our pilot county in October 2018. It will expand to other counties only after Medicaid ensures that Twin Falls County was successful.
		• Please join the Duals Stakeholder Updates to stay informed on this project. Stakeholder Update meeting information can be found on the MMCP webpage at http://mmcp.dhw.idaho.gov . The next meeting is scheduled for Monday June 25 at 2:00PM Mountain Time.
		• If you have any additional questions, please email IdahoMMCP@dhw.idaho.gov or call (208) 287-1156 and leave a message.

RECOMMENDATIONS & OTHER UPDATES		
Assignment Update	Alexandra Fernández Bureau Chief	Action: • Assignments from the March 21, 2018 PAO Meeting were completed as requested •
WRAP UP	Alexandra Fernández Bureau Chief	Action: • PAO Members have requested that updates on EVV, QA, MMCP and Idaho Medicaid Plus be added to the agenda as standing items.
ADJOURN		
		• Next Meeting will be on Wednesday, September 19, 2018

2018 Meeting Dates: March 21, 2018 (Video), June 20, 2018 (Video), September 19, 2018 (Video) and December 19, 2018 (Video)
All meetings will be held on Wednesday from 1-3 PM (MT) and 12-2PM (PT)

Personal Assistance Oversight Committee (PAOC)

6/20/18

Tammy Martin

Myers and Stauffer LC

WHAT IS A COST SURVEY?

Using financial records, providers complete a standardized form with financial and other statistical data.

Costs for each program are summarized and reported to the state using a standardized template.

State collects the cost survey for each provider to determine how much it costs the provider to provide an hour of service

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WHAT TYPE OF COSTS ARE REPORTED?

ALMOST ALL OF THEM!

- Must relate to the care being provided (if the company provides other services, those costs must be excluded).
- Must be related to patient care.

WAGES AND BENEFITS

- Direct care staff
- Program managers
- Administrative staff

ADMINISTRATIVE AND PROGRAM COSTS

- Program management
- Rent
- Utilities
- Property & equipment
- Licenses
- Banking
- etc

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

COST PER UNIT

ONE PROVIDER MAY REPORT $10,000 AND ANOTHER $2,000,000

FIND A COMMON DENOMINATOR

Need a common denominator to equalize cost to a cost per unit

SOLUTION – COST PER DIRECT CARE HOUR WORKED

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DETERMINE THE RATE

DIRECT CARE HOURLY WAGES

- Doesn’t come from the cost survey
- Idaho code requires it as the weighted average hourly pay rate nursing facilities and ICFs/IID pay their staff

EMPLOYEE BENEFITS

- Median cost per direct care hour worked from cost survey

PROGRAM RELATED EXPENSES

- Median cost per direct care hour worked from cost survey

ADMINISTRATIVE OVERHEAD COSTS

- Median cost per direct care hour worked from cost survey

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Q&A

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DEDICATED TO

GOVERNMENT HEALTH PROGRAMS

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Electronic Visit Verification

Overview for PAO

June 20, 2018

Background

- The EVV mandate is in the 21st Century CURES Act
- Section 12006 requires states to implement an EVV system:
  - For Personal Care Services (PCS) by1/1/19
  - For Home Health Services by 1/1/23
- Financial penalties will be imposed on the state for non-compliance*

EVV Requirements

The system must capture:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

As part of the implementation process, states must seek input from

- ❑ Family caregivers
- ❑ Individuals receiving and furnishing PCS or home health, and
- ❑ Other stakeholders

Three Implementation Options

OPTION 1	OPTION 2	OPTION 3
State requires providers to use one software solution.	State allows providers to use whatever software solution they want to use.	State takes a hybrid approach.

Challenges

- 1: Identifying services in scope.
  - Still waiting on additional guidance from CMS.
- 2: Ensuring consistent implementation across Medicaid programs.
- 3: Resources.

Opportunities

- Chance to work with stakeholders to improve programs and find efficiencies
  - Service plan and service delivery documentation
  - Quality assurance monitoring and reporting

Lessons Learned from Other States

- Start with an analysis of service definitions. Identify scope.
- Conduct an environmental scan. Current provider EVV adoption should play a role in our next steps.
- Thoughtful implementation is better than rapid implementation.

Idaho's Implementation Plan

Summer 2018	Spring 2019	Summer 2020
• Start stakeholder workgroups	• Begin rulemaking process	• Rules go into effect • Program goes live

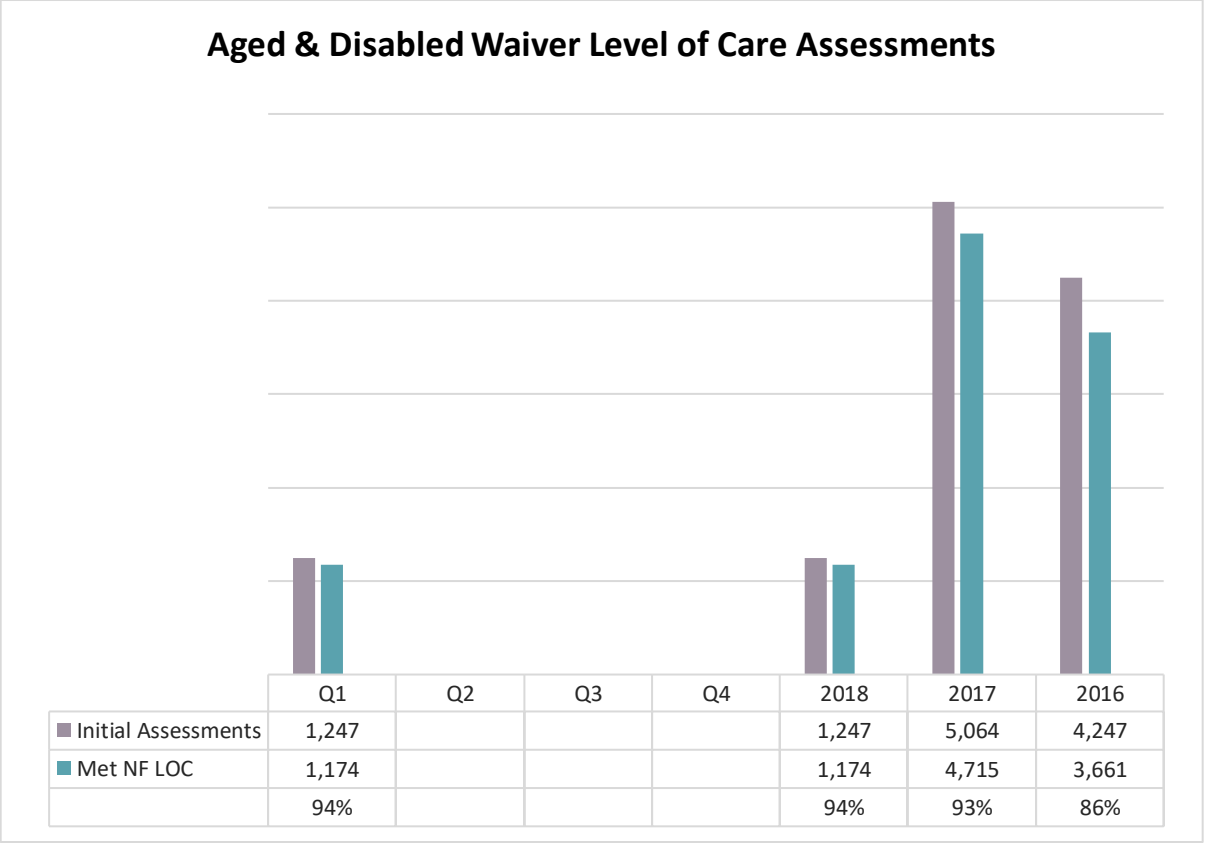
Bureau of Long Term Care Quality Improvement Strategy 2018

1.0 LEVEL OF CARE (LOC)

Assurance: The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver level of care consistent with care provided in a hospital, Nursing Facility or ICF/ID-DD.

Sub-assurance a: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Summary: Over 90% of new applicants for Aged & Disabled (A&D) Waiver services met Nursing Facility (NF) LOC during their initial assessment.



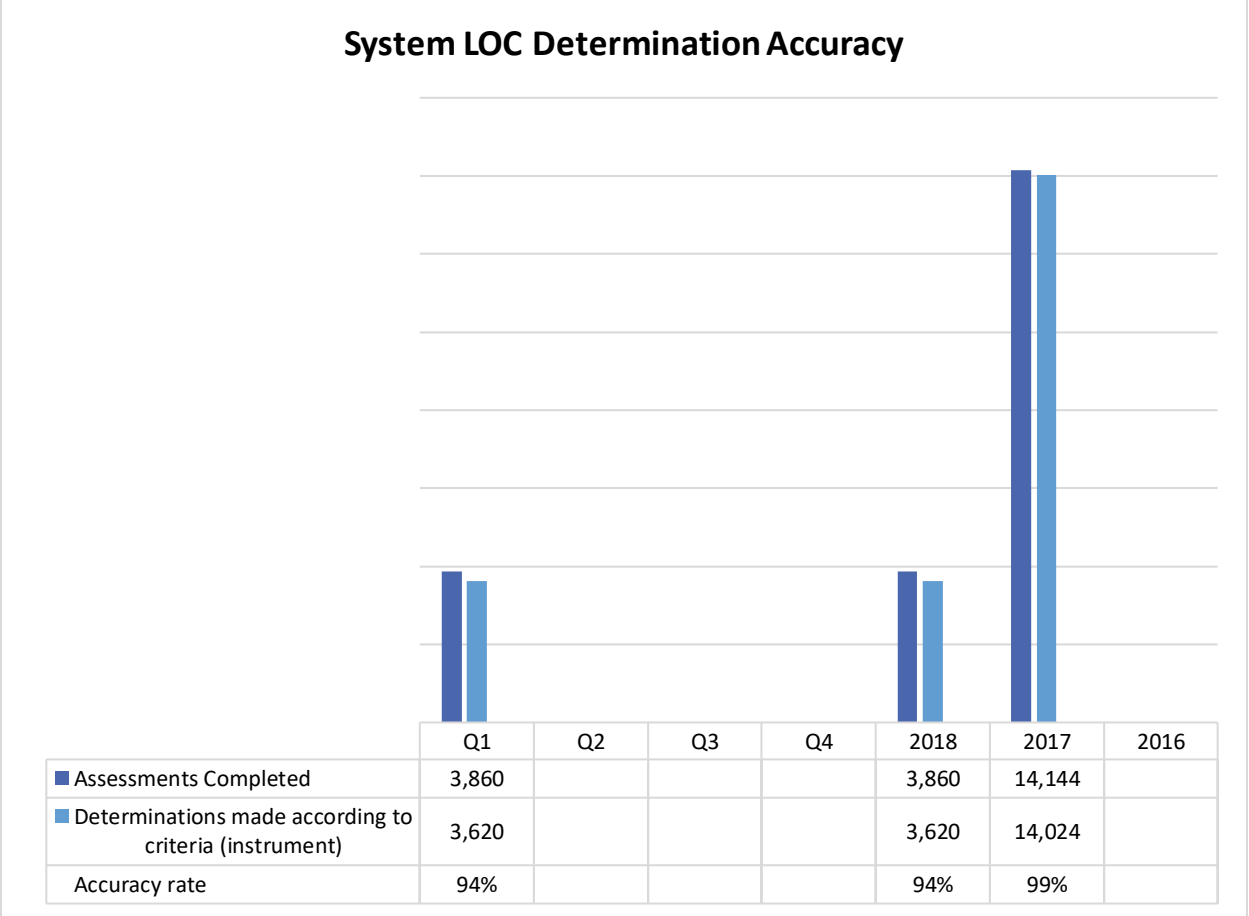
	Q1	Q2	Q3	Q4	2018	2017	2016
Initial Assessments	1,247				1,247	5,064	4,247
Met NF LOC	1,174				1,174	4,715	3,661
	94%				94%	93%	86%

Overview: The Level of Care Assessment is conducted by a Registered Nurse staffed with the Bureau of Long Term Care (BLTC). Assessments are conducted using the Uniform Assessment Instrument (UAI). The UAI is a set of standardized criteria used to assess a participants functional and cognitive abilities. The UAI provides a comprehensive assessment of a participants actual functioning level and unmet needs to determine the level of assistance required for the participant, including those elements that are necessary to develop an individualized person-centered service plan.

1.1 LEVEL OF CARE

Sub-assurance c: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Summary: The Assessment Certification Tool (ACT) has improved our ability to accurately capture data related to the LOC Determination Assessment. LOC determination accuracy remains high during quarter 1 of 2018. BLTC conducts routine maintenance on the ACT system and regularly performs system improvements to ensure accuracy for capturing Level of Care directly related to the Assessment. This level of data was not available in 2016.



	Q1	Q2	Q3	Q4	2018	2017	2016
Assessments Completed	3,860				3,860	14,144	
Determinations made according to criteria (instrument)	3,620				3,620	14,024	
Accuracy rate	94%				94%	99%	

Overview: Reporting mechanisms pull data from the ACT system to determine the total number of assessments completed and the total number of assessments completed accurately per the Level of Certification (LCERT) Part B. The LCERT Part B determines if the Nurse Reviewer accurately selected the appropriate Program per the Level of Care assessment or selected Level of Care Not Met if applicable. Nurse Managers utilize the new reporting mechanisms to monitor staff on a weekly basis and to identify trends to develop focused training for staff.

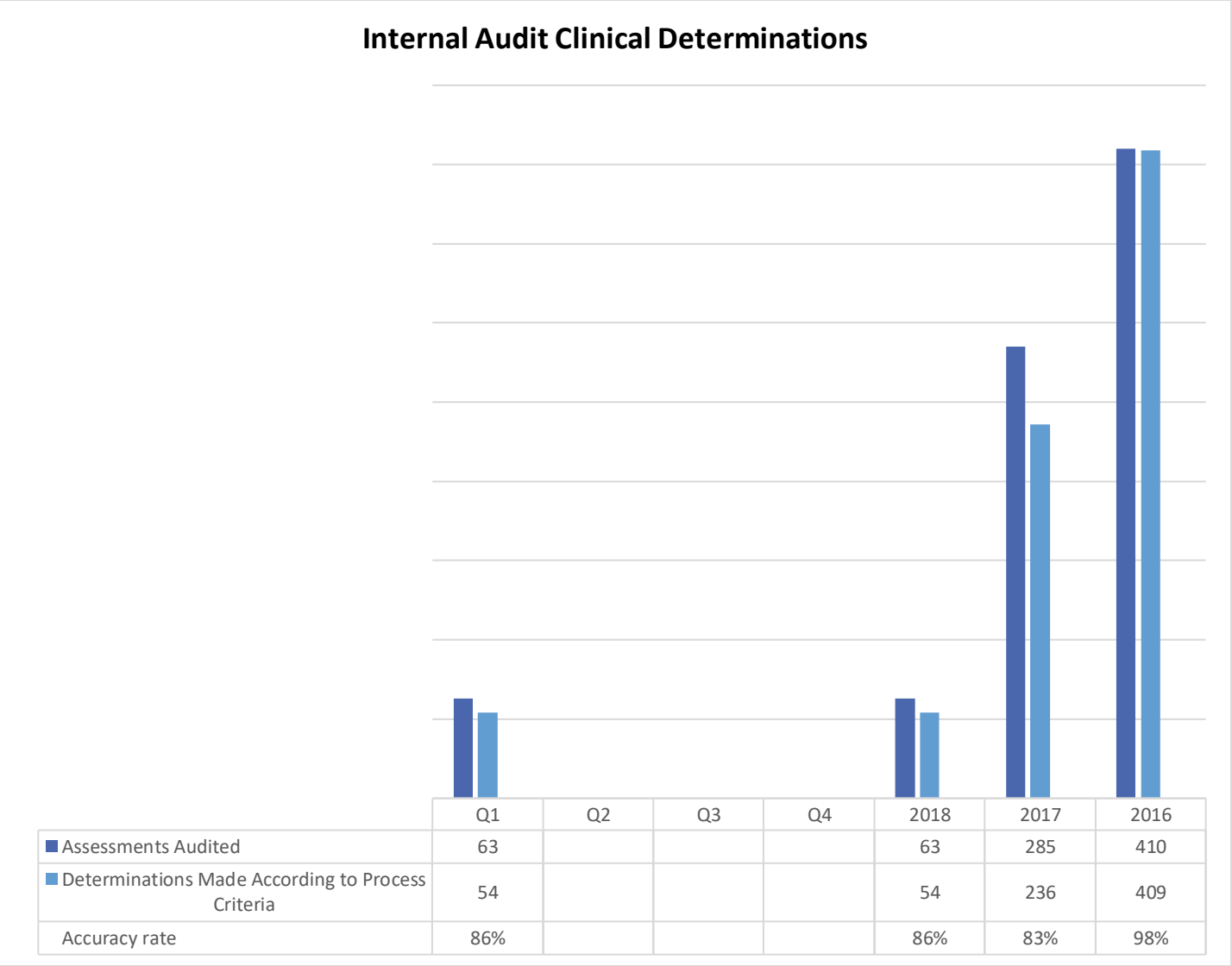
INTERNAL AUDIT

Summary: The Nurse Managers conduct a required quarterly internal audit utilizing data directly from the Assessment Tool. The audit is designed to review a representative sample of LOC Assessments in depth, reviewing criteria to ensure the Nurse Reviewer conducted an accurate assessment.

Remediation: Nurse Managers (NM) have determined the root cause of the identified deficiencies.

1. Inaccurate scoring and supporting narratives in the assessment.
2. Redetermination Assessments were not conducted within the 364-day timeline.

The NM's continue to provide staff training regarding system updates/enhancements and to ensure narratives in the assessment support LOC scoring. Additionally, BLTC is researching new operational processes to help ensure compliance on completing all LOC assessments in the required timelines.



	Q1	Q2	Q3	Q4	2018	2017	2016
Assessments Audited	63				63	285	410
Determinations Made According to Process Criteria	54				54	236	409
Accuracy rate	86%				86%	83%	98%

Overview: The Internal Audit is conducted by the Nurse Managers on a quarterly basis. The Nurse Manager conducts three internal file audits for each Nurse Reviewer with a focus on clinical criteria.

ANNUAL ASSESSMENT TIMELINES

Summary: BLTC reporting systems provide multiple tools to monitor the accuracy of adhering to timelines required to complete an annual assessment (364 days). The tools include:

1. A Worklist to identify upcoming LOC Annual Assessments.
2. A Late Annual Assessment Worklist and report.
3. The Internal Audit Report which tracks the number of days between the Redetermination date and the assessment being completed.

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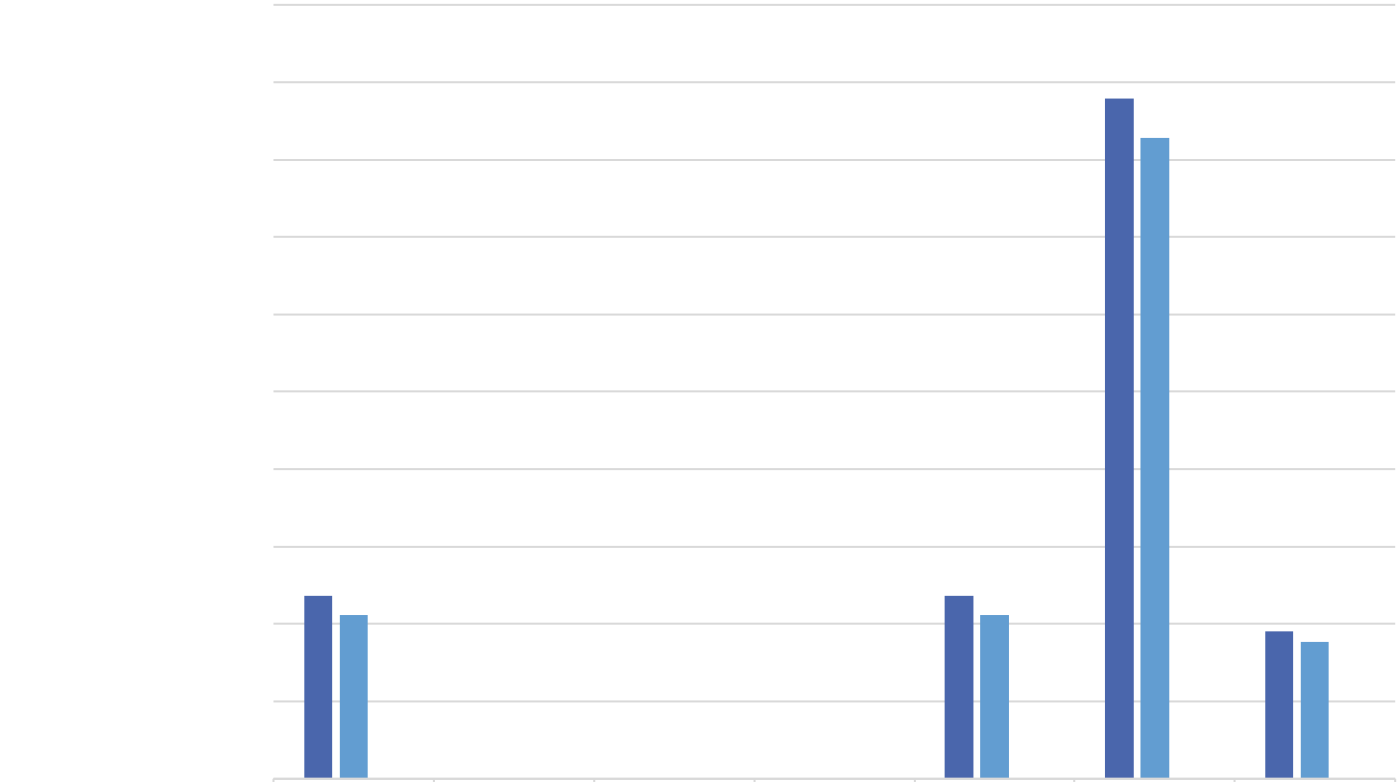
Remediation:
Managers monitor staff performance and provide training to ensure compliance. Staffing issues affect the compliance percentage. Throughout the first quarter, multiple BLTC nurses traveled to other regions to assist with timely completion of redetermination assessments. BLTC continues to look for innovative opportunities to complete assessments timely.



	Q1	Q2	Q3	Q4	2018	2017	2016
Assessments Completed	2,360				2,360	8,787	1,901
Completed Timely	2,110				2,110	8,276	1,772
Accuracy Rate	89%				89%	94%	93%

Overview: The ACT system allows for real time reporting on late assessments. This information is available to all BLTC staff to ensure that all redetermination assessments are completed within 364 days from the prior assessment. The BLTC has identified that meeting the required timelines of Annual Assessments is an area identified for improvement and has developed specific tools and reports to help managers identify trends such as caseload distribution, participant geographic areas and staff performance.

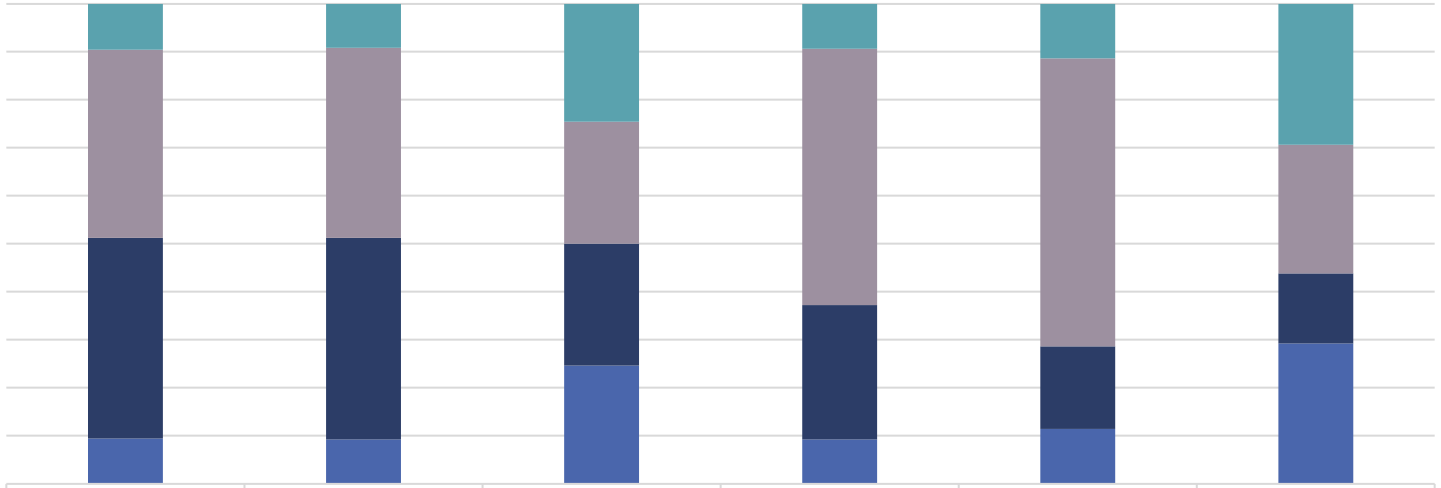
2.0 QUALIFIED PROVIDERS (LICENSED)

Assurance: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-assurance a: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Summary: Initial applications for Certified Family Home and Residential Assisted Living Facility Certification and RALF Licensure request reviews were conducted by the Division of Licensing and Certification (L&C). Any facility that is not compliant is not certified and a license is not issued.

Certified Family Home/Residential Assisted Living Facility Initial Provider Enrollment



	CFH Initial Certification Requests	CFH MetCertification Requests	CFH Compliance Percentage	RALF Initial Licensure Requests	RALF Met Licensure Standards	RALF Compliance Percentage
2018	55	53	96%	4	4	100%
2017	228	227	100%	23	21	91%
2016	242	242	100%	12	6	50%
Q1	55	53	96%	4	4	100%
Q2						
Q3						
Q4						

Overview: L&C manage the certification program for Certified Family Homes (CFH) and the licensing program for Residential Assisted Living (RALF) Facilities. L&C is responsible for the certification/licensing, inspection and survey of these provider types.

2.1 QUALIFIED PROVIDERS (LICENSED)

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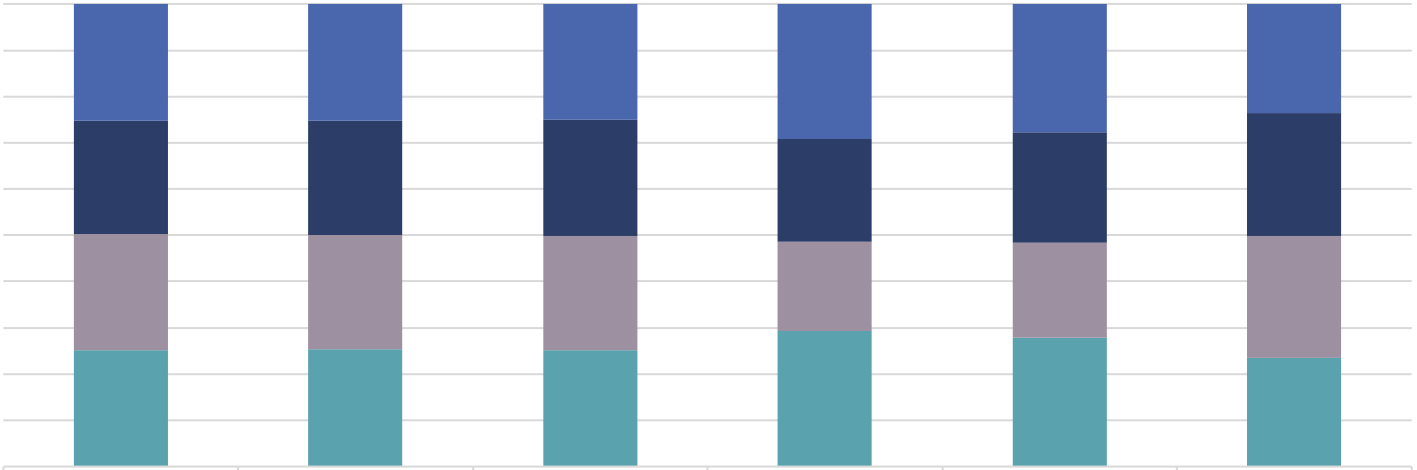
Sub-assurance a: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services

Summary: L&C conducts all recertification assessments to determine if licenses will remain active. If standards are not met L&C manages all deficiencies associated with the licensure and certification standards.

Certified Family Home/Residential Assisted Living Facility Existing Provider Enrollment



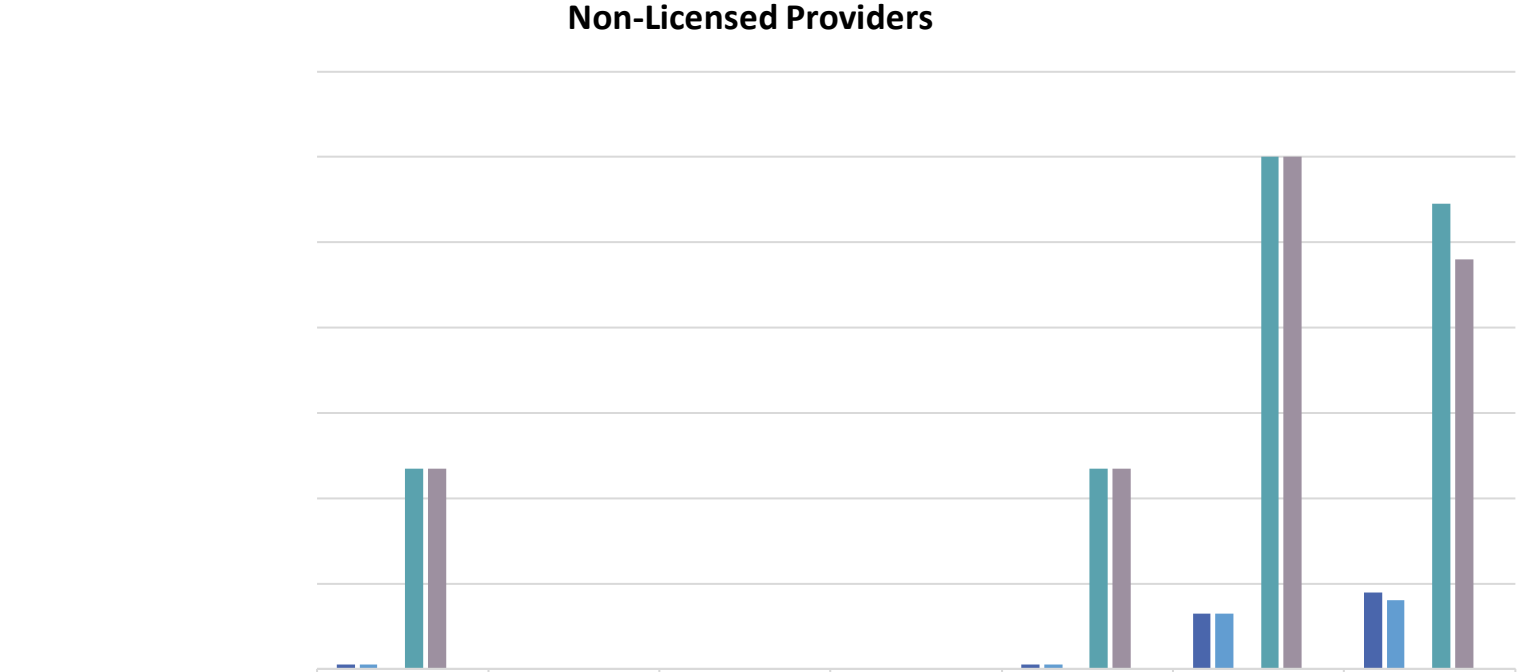
	CFH Existing Licensed/Certified Providers	CFH Met Licensure/Certification Standards	Compliance Percentage	RALF Existing Licensure/Certified Providers	RALF Met Licensure/Certification Standards	Compliance Percentage
Q4						
Q3						
Q2						
Q1	2,466	2,466	100%	360	274	76%
2016	2,408	2,408	100%	273	235	86%
2017	2,452	2,415	98%	239	203	85%
2018	2,466	2,466	100%	360	274	76%

Overview: L&C manage the ongoing certification and licensure requirements for Certified Family Homes (CFH) and Residential Assisted Living (RALF) Facilities.

2.2 QUALIFIED PROVIDERS (NON- LICENSED)

Sub-assurance b: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Summary: Audits continue to be completed by required deadlines. Process improvements have contributed to BLTC's improvement in meeting required timelines, and we continue to evaluate our operational processes to further enhance our audit process.



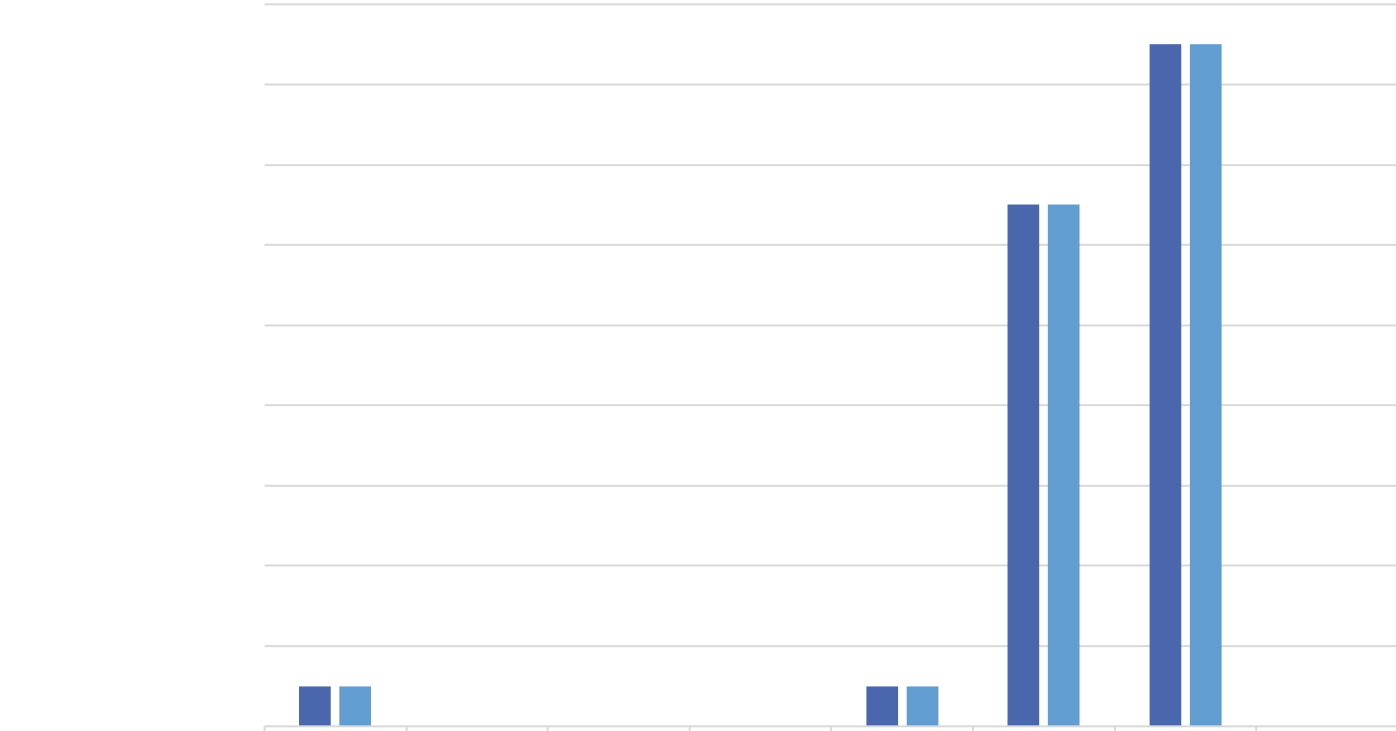
	Q1	Q2	Q3	Q4	2018	2017	2016
Initial Provider Applicants	1				1	13	18
6 month Reviews Completed	1				1	13	16
	100%				100%	100%	89%
Provider Reviews Due	47				47	120	109
Biennial Reviews Completed	47				47	120	96
	100%				100%	100%	88%

Overview: Biennial audits are conducted for all providers that conduct services for participants receiving State Plan Personal Care Services and A&D Waiver services. Additionally, BLTC has oversight to review policies and procedures for new non-licensed providers to ensure compliance to all IDAPA rules and contractual obligations. The provider auditing methodologies include a comprehensive provider self-audit and a BLTC desk audit that is completed prior to the on-site provider audit.

2.2 QUALIFIED PROVIDERS (NON- LICENSED)

Sub-assurance c: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Summary: All newly eligible providers approved in quarter 1 of 2018 were provided training.



	Q1	Q2	Q3	Q4	2018	2017	2016	
Initial Providers	1				1	13	17	
Initial Provider Training	1				1	13	17	
	100%	0%	0%	0%	100%	100%	100%	

Overview: Upon approval of policies and procedures for initial non-licensed providers, training for the provider agency is required prior to any services being delivered to Idaho Medicaid participants. Training is conducted by Quality Improvement Specialist staff within the BLTC.

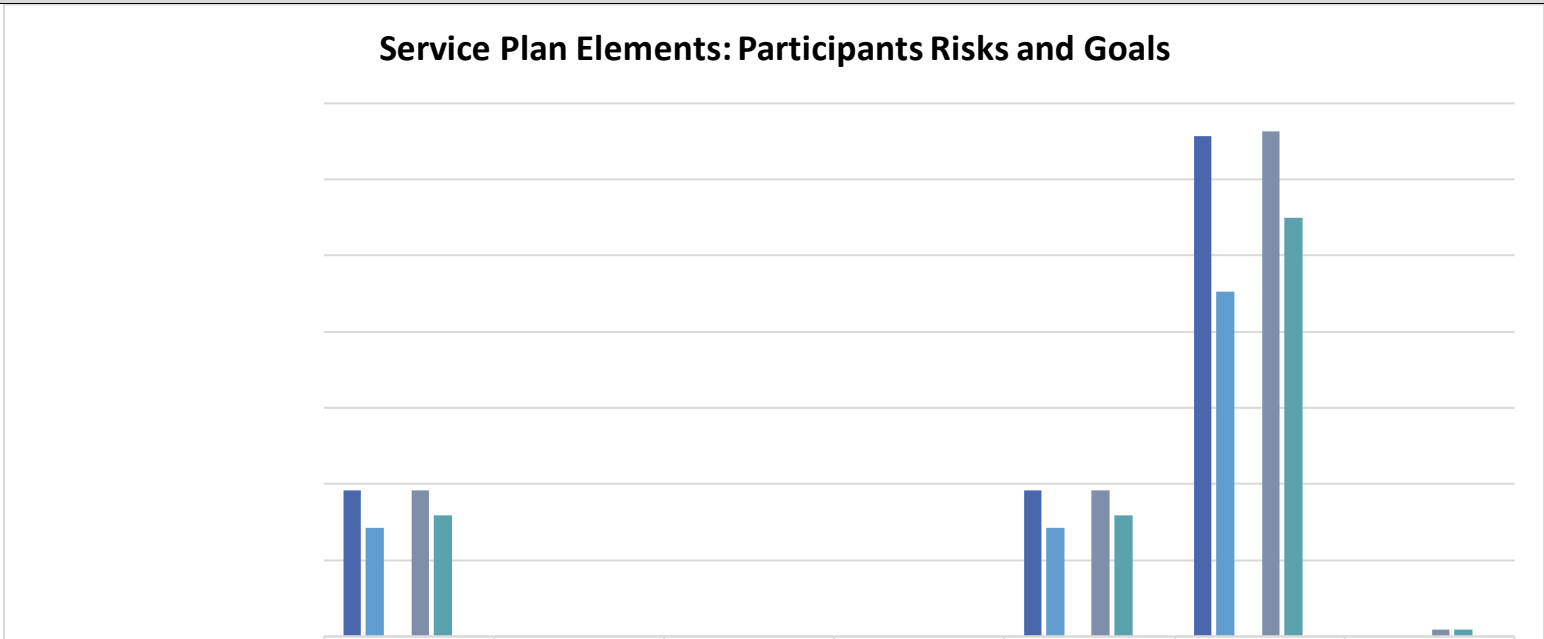
3.0 SERVICE PLANS

Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurance a: Service plans address all members assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Summary: Nurse Reviewers audit and report on 100% of Service Plans at the time the Annual Assessment. The data is distributed to providers on a quarterly basis. The BLTC QA team monitors the data to provide technical assistance to providers to ensure remediation of deficient Service Plans.

Remediation: Quality Survey Reports are sent to providers on a quarterly basis with deficiencies clearly identified. Immediate remediation is expected by all providers. BLTC QA staff continue to train providers on service plan development.



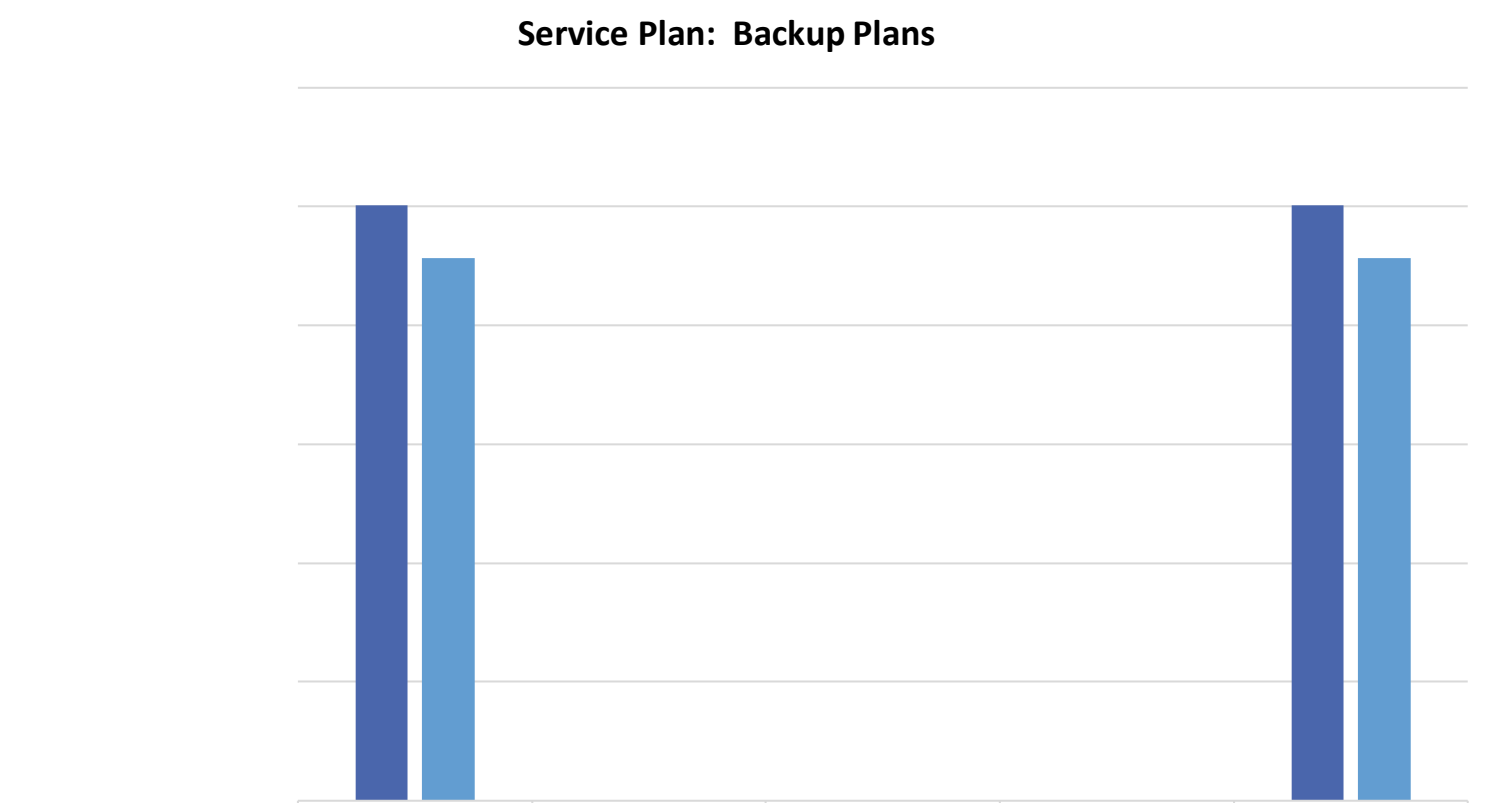
	Q1	Q2	Q3	Q4	2018	2017	2016
Total SP Reviewed-Goals	1,913				1,913	6,569	
Total Plans Compliant	1,431				1,431	4,529	
Compliance Percentage	75%				75%	69%	
Total SP Reviewed-Risks	1,912				1,912	6,633	95
Total Plans Compliant	1,584				1,584	5,496	92
Compliance Percentage	83%				83%	83%	55%

Overview: Participant Service Plans are developed by the providers based on the findings from the LOC Assessment. Risks and Goals are required elements that are reviewed on an annual basis by the Nurse Reviewer at the time of the Annual Assessment. The Service Plan review sampling method was modified from a representative population sampling through the provider Quality Assurance (QA) process to a whole (100%) audit. This approach is expected to improve Service Plans for participants and better identify quality improvement areas that need to be addressed.

3.1 SERVICE PLANS.

Sub-assurance a: Service plans address all members assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Summary: The Backup Plan is a component of the BLTC Service Agreement that is sent to all providers upon the completion of the LOC Assessment. Most providers have adopted the IDHW Service Agreement as their participant Service Plan which helps to ensure compliance with the Backup Plan. Providers with identified deficiencies are provided technical assistance as necessary to ensure compliance.



	Q1	Q2	Q3	Q4	2018
Service Plans Reviewed	501				501
Service Plans Compliant	457				457
	91%				91%

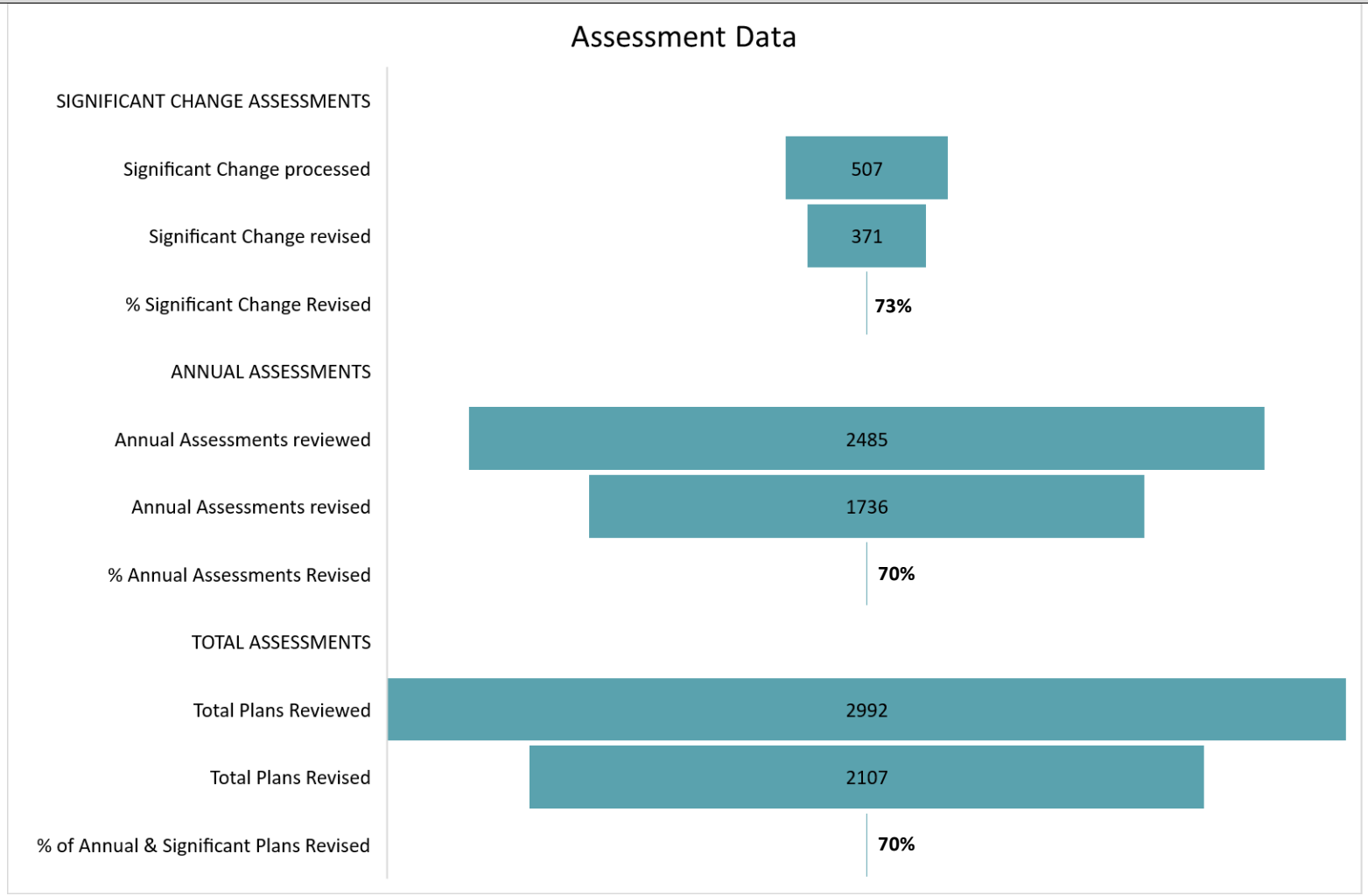
Overview: Participant Service Plans are developed by the providers based on the findings from the LOC Assessment. Backup Plans are a required element and are reviewed biennially by Quality Improvement Specialists at the time of the provider audit. The current audit sample size is 30% of the entire Medicaid population serviced by the identified provider.

3.2 SERVICE PLANS

Sub-assurance b: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs

Summary: Reporting has identified that 70% of all Annual Assessments are revised from the previous year's LOC score. Over 70% of Significant Change Assessments are revised from the existing assessment score. Providers are not reporting Significant Changes as often as Annual Assessments indicate.

Remediation: BLTC continues to offer training to providers in the importance of identifying and reporting Significant Changes to participants LOC needs.



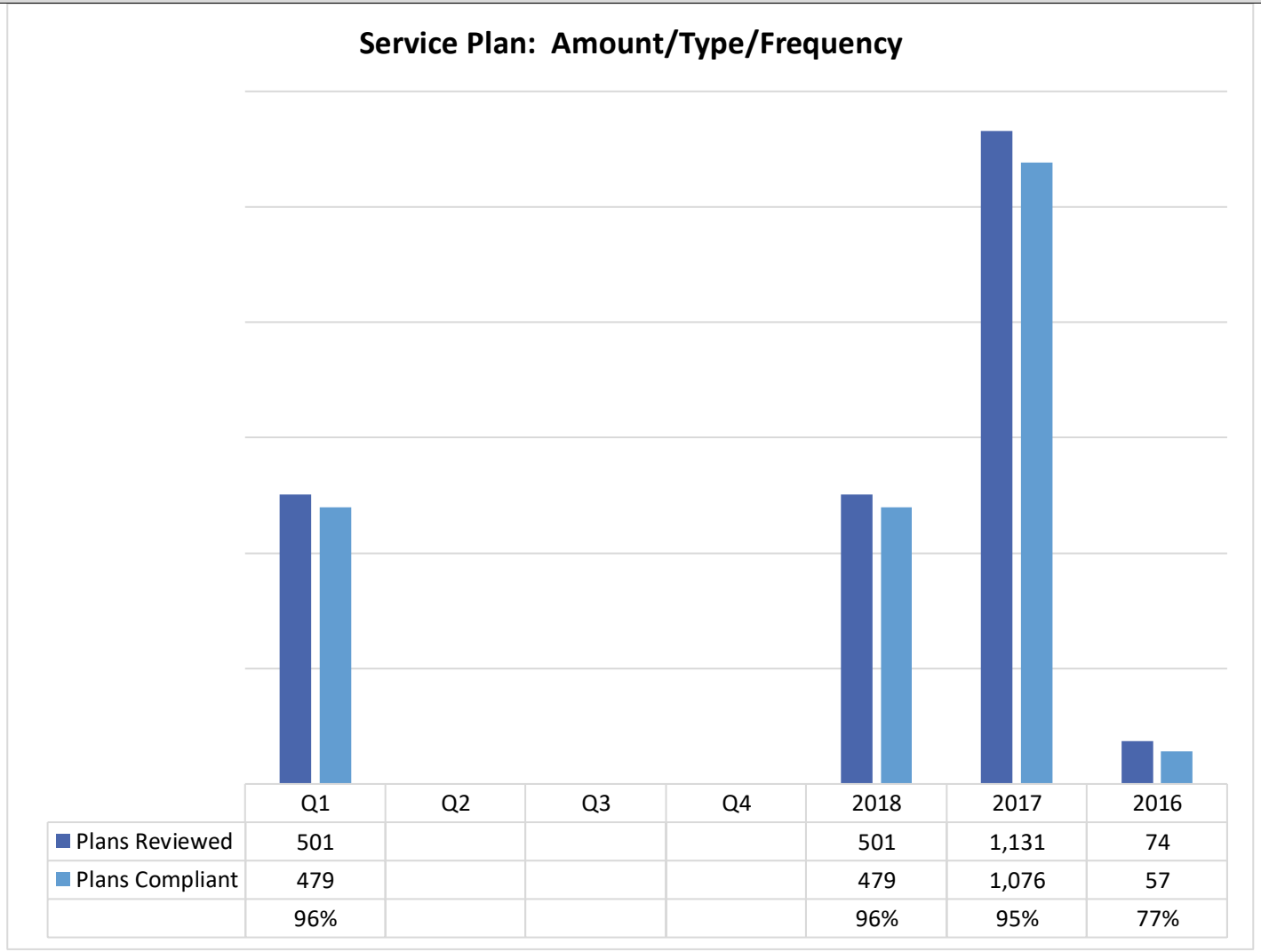
Overview: Significant Change is identified as any change in services after the Annual or Initial LOC Assessment has been completed. Significant Changes generally result in a change in the LOC score.

3.3 SERVICE PLANS

Sub-assurance c: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Summary: Providers are required to identify Amount/Type and Frequency on the participant Service Plan. Quality Assurance Specialists review a 30% sample size of all Service Plans at the time of the biennial provider audit.

Remediation: Providers with deficiencies are provided individualized technical assistance at the time of the Provider Audit. Providers with deficiencies are closely monitored and targeted annual reviews may be conducted to ensure compliance to all rules and regulations.



	Q1	Q2	Q3	Q4	2018	2017	2016
Plans Reviewed	501				501	1,131	74
Plans Compliant	479				479	1,076	57
	96%				96%	95%	77%

Overview: The Service Plan is required to be completed by all provider types in accordance with IDAPA regulations. The Amount/Type and Frequency requirements are monitored by the Quality Improvement Specialist staff at the time of the provider audit.

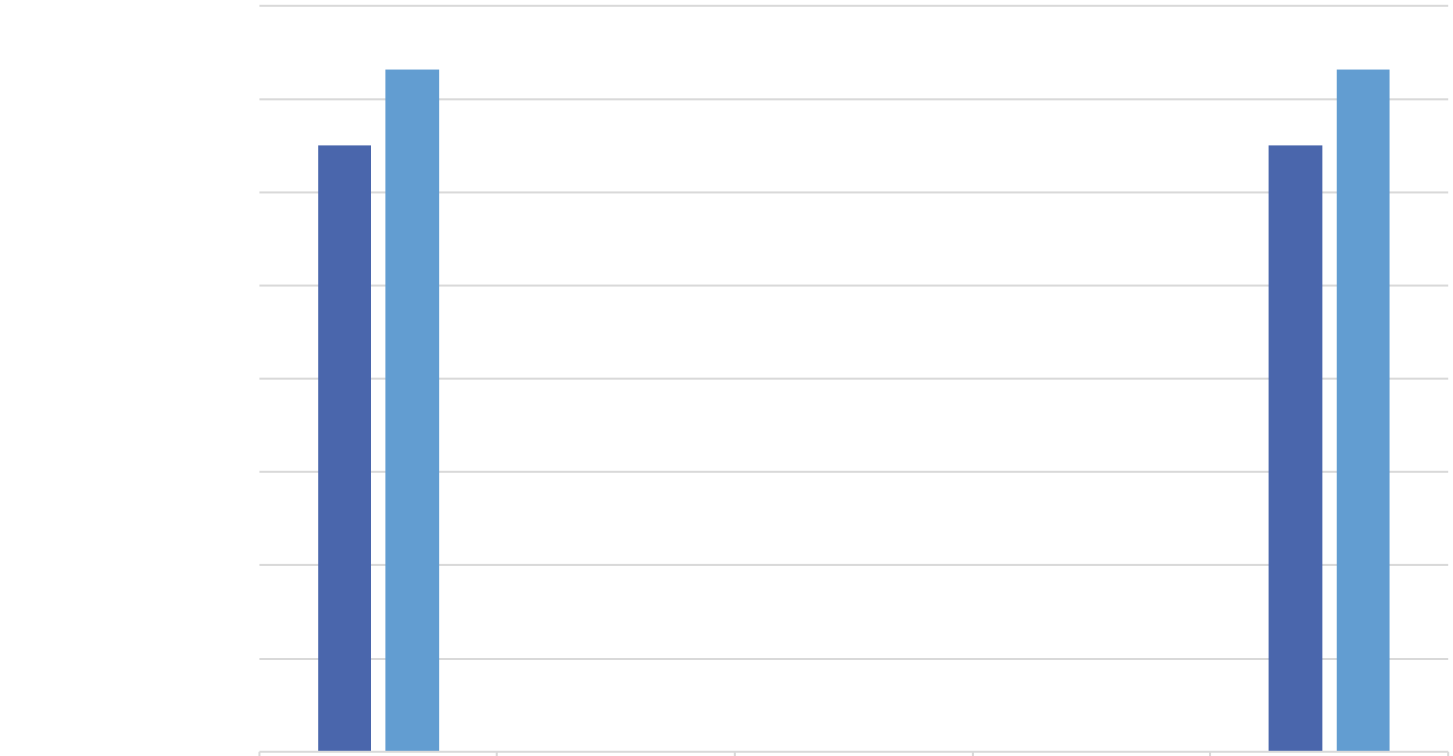
3.4 SERVICE PLANS

Sub-assurance d: Participants are afforded choice between/among waiver services and providers.

Summary: BLTC monitors Provider Choice by reporting mechanisms that identify if the correct forms are on file. BLTC has identified that the deficiency identified is due to Managed Care Organizations (MCO) not attaching the Provider Choice documentation to each participant file with the Medicare Medicaid Coordinated Plan (MMCP) in a timely manner.

Remediation: The MCO were uploading documentation on a quarterly basis and are now required to upload on a weekly basis.

Service Plan: Participant Acknowledgment for Provider/Service Choice



	Q1	Q2	Q3	Q4	2018
Provider Choice on file	3,254				3,254
Records reviewed	3,657				3,657
	89%				89%

Overview: All participants for PCS and A&D Waiver services are afforded choice between/among waiver services and providers. Reporting allows for 100% sample size audit to ensure each participant's provider and service choice acknowledgement form is on file, validating this measure.

4.0 HEALTH & WELFARE

Assurance: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

Sub-assurance a: The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Summary: Complaints related to Abuse/Neglect/Exploitation are identified within the BLTC Complaint database and are investigated within the appointed timeframes.

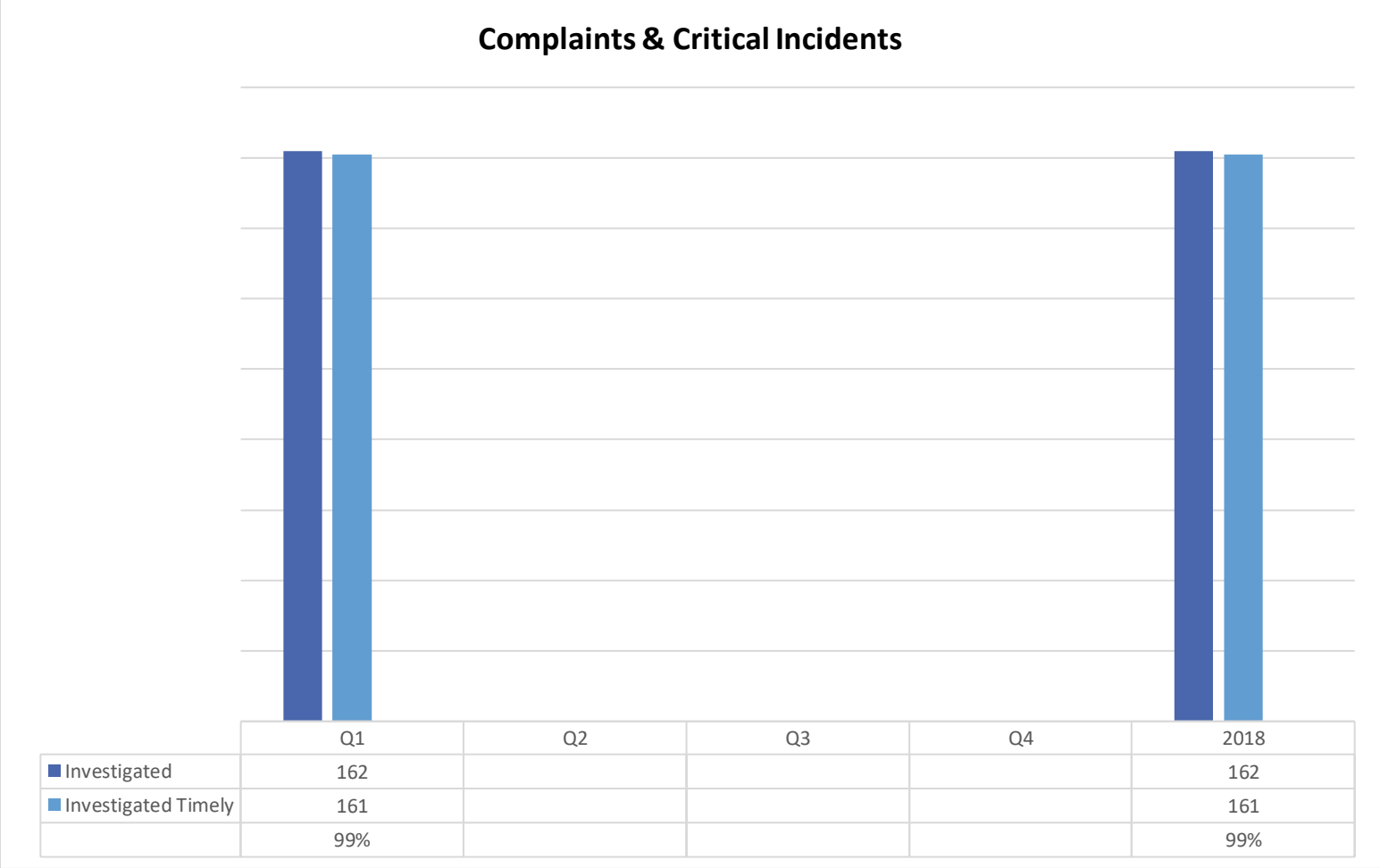
	Q1	Q2	Q3	Q4	2018 Total
Reported	19				19
Investigated	19				19
Substantiated	12				12
Remediated	12				12
	100%				100%

Overview: Complaints intake is the responsibility of all available staff within the BLTC. Regional Nurse Reviewers are first responders to all complaints. After reporting to Adult Protection or Law Enforcement all complaints related to Abuse/Neglect or Exploitation are immediately forwarded to Quality Assurance Specialist staff for further investigation. Additionally, the UAI indicator of Abuse/Neglect or Exploitation is designed to immediately notify the QA staff as well.

4.1 HEALTH & WELFARE

Sub-assurance b: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Summary: Nurse Managers are designated as front-line staff to triage and investigate all complaints and determine severity through the Complaints database. The database captures the remediation and outcome of all complaints and tracks timelines to ensure compliance.



	Q1	Q2	Q3	Q4	2018
Investigated	162				162
Investigated Timely	161				161
	99%				99%

Overview: The BLTC Complaint Intake database is available to all BLTC staff for the intake of all complaints. Regional Nurse Managers are the first responders to all complaints and determine if further assistance is required from QA staff, Adult Protection or Law Enforcement.

5.0 FINANCIAL ACCOUNTABILITY

Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

Sub-assurance a: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. **Sub-assurance b:** The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.	*Because of changes to waiver performance measures that were implemented in July 2016, data collection points and graphs for the sub-assurances under this waiver assurance were removed from this report beginning in 2017. Compliance with financial accountability areas is monitored and reported via other mechanisms, including the Medicaid Program Integrity Unit (MPIU) and the Bureau of Financial Operations. The MPIU identifies Medicaid overutilization of services by providers and participants, and routinely monitors for improper billing patterns. The MPIU also conducts special studies to make program and system recommendations. Internal BLTC processes include referrals to MPIU when potential improper billing patterns are identified. The Bureau of Financial Operations ensures that reimbursement rates are consistent with the approved waiver methodology.

BLTC – OTHER PROGRAM RELATED SUMMARY REPORTS

MONEY FOLLOWS THE PERSON DEMONSTRATION GRANT - IDAHO HOME CHOICE

Overview: Idaho Home Choice (IHC) is a program funded by a federal grant. The program is designed to assist Medicaid participants overcome barriers that would prohibit them from returning to a Community Based Living Situation.

Summary: IHC exceeded benchmarks in 2012 thru 2015. For CY2016 and 2017 compliance was met by 98%.

Waiver	Q1	Q2	Q3	Q4	2018 Total	2017 Total	2016 Total	2015 Total	2014 Total	2013 Total	2012 Total	2011 Total	Total IHC
DD Waiver	2				2	17	13	16	14	14	16	2	92
A&D Waiver	16				16	40	67	60	79	57	49	2	354
Enhanced	1				1	19	16	6	3	3	1	0	48
Total	**19**				**19**	**76**	**96**	**82**	**96**	**74**	**66**	**4**	**513**
Qualified Institution	**Q1**	**Q2**	**Q3**	**Q4**	**2018 Total**	**2017 Total**	**2016 Total**	**2015 Total**	**2014 Total**	**2013 Total**	**2012 Total**	**2011 Total**	**Total IHC**
ICF/ID	2				2	15	12	12	11	11	14	3	80
IMD	1				1	7	8	1	2	7	5	1	32
SNF	16				16	54	76	69	83	56	47	0	401
Total	**19**				**19**	**76**	**96**	**82**	**96**	**74**	**66**	**4**	**513**
Qualified Residence	**Q1**	**Q2**	**Q3**	**Q4**	**2018 Total**	**2017 Total**	**2016 Total**	**2015 Total**	**2014 Total**	**2013 Total**	**2012 Total**	**2011 Total**	**Total IHC**
Supported Living	0				0	8	9	12	13	10	11	1	64
Apartment	10				10	34	54	41	37	36	27	1	240
Own Home	2				2	9	13	14	18	16	14	0	86
Family's Home	2				2	12	8	0	16	9	9	0	56
CFH	5				5	13	12	15	12	3	3	2	65
RALF	0				0	0	0	0	0	0	2	0	2
Total	**19**				**19**	**76**	**96**	**82**	**96**	**74**	**66**	**4**	**513**

PRE-ADMISSION SCREENING & ANNUAL RESIDENT REVIEW (PASRR) PROGRAM

PASRR Totals by Region

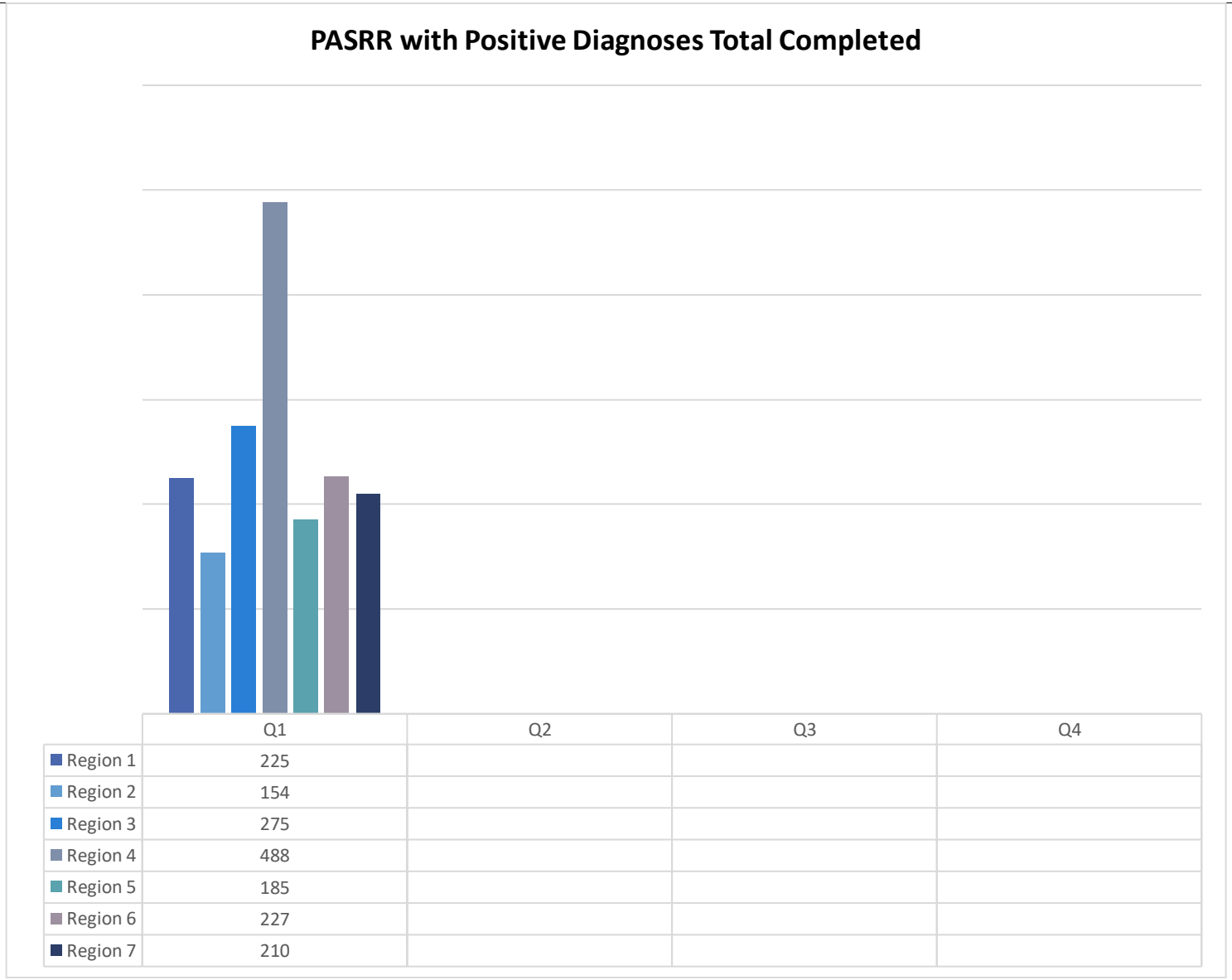
Overview: PASRR operation is required of the BLTC Nurse Reviewers based on federal rule.
PASRR is conducted at the time an individual is recommended by a physician for a Nursing Facility admission. The program ensures that individuals with mental illness or intellectual disabilities meet Nursing Facility Level of Care and receive Specialized Services during their stay.

PASRR Total by Region	Q1	Q2	Q3	Q4	2018 Total	2017 Total	2016 Total
Region 1	226				226	1,038	1,054
Region 2	155				155	620	610
Region 3	279				279	1,166	1,058
Region 4	491				491	2,222	1,729
Region 5	192				192	879	964
Region 6	227				227	1,134	1,094
Region 7	212				212	817	785
Total	**1,782**				**1,782**	**7,876**	**7,294**

PASRR Total % by Region	Q1	Q2	Q3	Q4	2018 Total
Region 1	13%				13%
Region 2	9%				9%
Region 3	16%				16%
Region 4	28%				28%
Region 5	11%				11%
Region 6	13%				13%
Region 7	12%				12%
Total	100%				100%

PASRR Reviews with a Positive Diagnosis- Total Completed

Summary: 1,782 PASRR's were completed during quarter 1 of 2018. Of the PASRR's completed, 81% (1,764) of them had positive diagnoses.

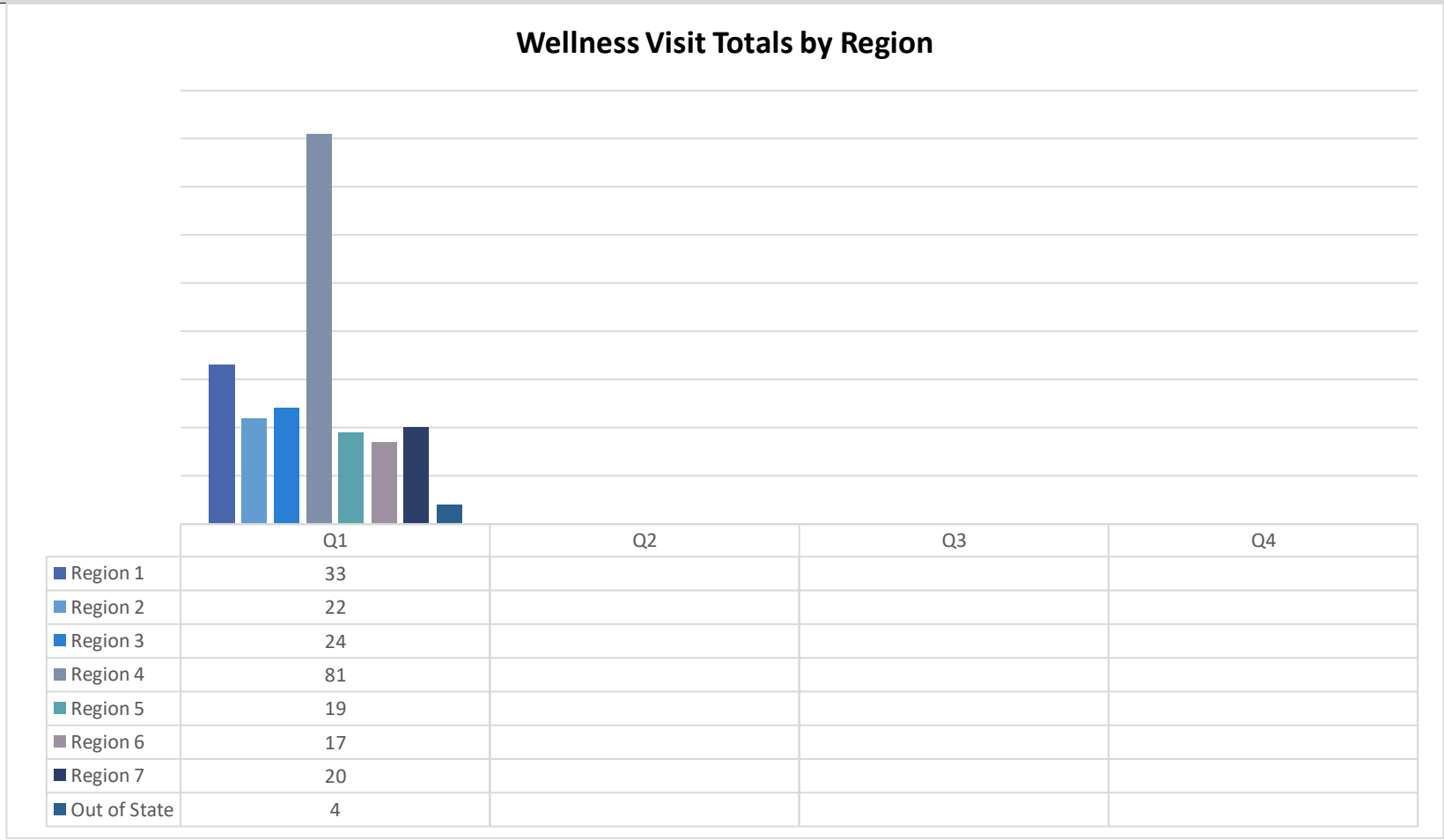


	Q1	Q2	Q3	Q4
Region 1	225			
Region 2	154			
Region 3	275			
Region 4	488			
Region 5	185			
Region 6	227			
Region 7	210			

WELLNESS VISITS

Wellness Visit Totals by Region

Overview: BLTC has recently started collecting Wellness Visit data to analyze how many participants are accessing annual wellness services. For quarter 1 of 2018, 220 participants accessed wellness-related services.



	Q1	Q2	Q3	Q4
Region 1	33			
Region 2	22			
Region 3	24			
Region 4	81			
Region 5	19			
Region 6	17			
Region 7	20			
Out of State	4			

Idaho Home Choice Benchmark Updates
10/01/2011 through 05/31/2018

Calendar Year	Elderly	Individuals with ID/DD	Physically Disabled	Anticipated Benchmark Total	Actual Benchmark Total
2011	5	1	2	8	4
2012	30	5	18	53	66
2013	20	10	35	65	74
2014	50	10	40	100	96
2015	43	7	32	80	82
2016	36	15	45	97	96
2017	35	15	47	97	76
2018	35	20	32	87	25
Total	253	78	251	587	519

Funding Received and Expended

2011 Funding Expended	2012 Funding Expended	2013 Funding Expended	2014 Funding Expended	2015 Funding Expended	2016 Funding Expended
$194,986	$1,628,061	$2,822,747	$4,992,965	$2,822,389	$3,379,508
2017 Funding Expended	**2018 Funding Requested**				
$3,391,361	$3,904,243				

Transitions
10/1/2011 – 05/31/2018

Q4 2011	October	November	December	Total
Transitions	0	3	1	4
			Total 2011	4
Q1 2012	**January**	**February**	**March**	**Total**
Transitions	2	3	2	7
Q2 2012	**April**	**May**	**June**	**Total**
Transitions	1	5	8	14
Q3 2012	**July**	**August**	**September**	**Total**
Transitions	5	6	8	19
Q4 2012	**October**	**November**	**December**	**Total**
Transitions	7	13	6	26
			Total 2012	66
Q1 2013	**January**	**February**	**March**	**Total**
Transitions	4	5	5	14
Q2 2013	**April**	**May**	**June**	**Total**

Transitions	7	7	9	23
Q3 2013	July	August	September	Total
Transitions	3	12	6	21
Q4 2013	October	November	December	Total
Transitions	4	7	5	16
			Total 2013	74
Q1 2014	January	February	March	Total
Transitions	10	5	9	24
Q2 2014	April	May	June	Total
Transitions	7	9	5	21
Q3 2014	July	August	September	Total
Transitions	8	9	10	27
Q4 2014	October	November	December	Total
Transitions	10	7	7	24
			Total 2014	96
			Program Total	240
Q1 2015	January	February	March	Total
Transitions	7	6	10	23
Q2 2015	April	May	June	Total
Transitions	10	5	5	20
Q3 2015	July	August	September	Total
Transitions	12	5	10	27
Q4 2015	October	November	December	Total
Transitions	3	5	4	12
			Total 2015	82
			Program Total	322
Q1 2016	January	February	March	Total
Transitions	5	11	14	30
Q2 2016	April	May	June	Total
Transitions	5	2	8	15
Q3 2016	July	August	September	Total
Transitions	11	11	4	26
Q4 2016	October	November	December	Total
Transitions	5	10	10	25
			Total 2016	96
			Program Total	418
Q1 2017	January	February	March	Total
Transitions	4	13	10	27
Q2 2017	April	May	June	Total
Transitions	4	6	8	18
Q3 2017	July	August	September	Total
Transitions	5	8	8	21
Q4 2017	October	November	December	Total
Transitions	2	5	3	31
			Total 2017	76
			Program Total	494
Q1 2018	January	February	March	Total
Transitions	9	9	2	20
Q2 2018	April	May	June	Total

Transitions	2	3		5
Q3 2018	July	August	September	Total
Transitions				
Q4 2018	October	November	December	Total
Transitions				
			Total 2018	25
			Program Total	519

DEMOGRAPHICS									
Type of Program	**<65**	**65+**	**TOTAL**						
DD Waiver	91	4	95						
A & D Waiver	202	174	376						
Enhanced Plan	33	15	48						
Type of Institution									
ICF/ID	77	4	81						
IMD	30	3	33						
SNF	219	186	405						
Type of Residence									
Supported Living/Res Hab	61	4	65						
Apartment	151	93	244						
Own Home	34	51	85						
Family's Home	40	17	57						
RALF	1	1	2						
CFH	39	27	66						
Region									
1	21	18	39						
2	20	17	37						
3	96	62	158						
4	97	58	155						
5	22	16	38						
6	61	17	78						
7	9	5	14						
Reason Program Ended									
Re-institutionalized	15	16	31						
Deaths	16	53	69						
Went to Non-Qualified Residence	2	3	5						
Completed 365 Days	241	123	369						
Institutionalization									
Average number of days institutionalized	1172	766	969						
Additional Demographics	**Idaho**	**Nationwide**							
Average Age/From 18 to 101 Years of Age	58	58							
Average days to Discharge	81	118							
Reinstitutionalization Rate	6.0%	11.0%							

Unduplicated Counts	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Skilled Nursing Facility	4,695	4,610	4,608	4,494	4,432	5,483	5417	5240	
ICF/ID	484	453	446	443	439	478	430	420	
A & D Waiver	9,903	9,667	9,838	9,795	10,370	10,392	10,625	10,799	
DD Waiver	2,704	3,073	3,252	3,583	3,394	3,955	4,230	4,520	

Idaho Medicaid
Dual Eligible Program Options FAQ's

Who Are "Duals?"

Dual eligible individuals are 21 years of age or older and receive both Medicare (Parts A, B and D) *and* Enhanced Medicaid coverage. There are approximately 27,000 Duals individuals in the state of Idaho.

Why does Idaho have programs just for Duals?

Medicaid was legislatively mandated to find a solution for the high cost of Dual's healthcare. The typical dual-eligible individual has more than four times the expenditures than Medicare-only beneficiaries. Idaho Dual eligible individuals make up 15% of Idaho's Medicaid population but require over one third (1/3) of the Medicaid budget. IDHW is joining the majority of states across the US to look for innovative solutions to coordinate benefits, manage costs and improve healthcare options for Dual Eligibles based on their individual needs and preferences.

What Is Coordinated Care?

Coordinated Care is the coverage and integration of Medicare and/or Medicaid benefits through a single entity, which means:

One set of comprehensive benefits. **One** accountable entity to coordinate delivery of services.
One care management team to coordinate care.

What programs are available for Dual's?

The **Medicare Medicaid Coordinated Plan** (MMCP) is a voluntary program that integrates Medicare and Medicaid benefits into a single healthcare plan. Duals may enroll or disenroll from this plan at any time. The **Idaho Medicaid Plus** plan is a mandatory program for Medicaid benefits only.

What are the health plans for MMCP and Idaho Medicaid Plus?

Blue Cross of Idaho and **Molina** Healthcare of Idaho administer the plans in the following counties:

Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, Twin Falls

Blue Cross of Idaho also has the MMCP available in these additional counties: Boise, Boundary, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Madison, Minidoka, Owyhee, Payette, Power

What is the MMCP?

The Medicare Medicaid Coordinated Plan is a health plan that coordinates Medicare benefits as well as most of the Medicaid benefits plus some supplemental services.

What is Idaho Medicaid Plus?

Idaho Medicaid Plus is a plan for dual eligible beneficiaries that coordinates most of their Medicaid benefits through a health plan.

What is the difference between the MMCP and Idaho Medicaid Plus?

	MMCP	Idaho Medicaid Plus
Medicare Included	Yes	No
Mandatory Enrollment	No	Yes
Premium	No	No
Participant Choice	Yes	Yes
Available Today	Yes	Coming Soon
Care Coordination	Yes	Yes
Supplemental Benefits	Yes	No
Plan Choices	Blue Cross of Idaho *or* Molina Healthcare of Idaho	Blue Cross of Idaho o*r* Molina Healthcare of Idaho

What benefits do these programs cover?

Medicare Medicaid Coordinated Plan	Idaho Medicaid Plus
The MMCP covers all medically-necessary and preventive services covered under **Medicare** Part A, Part B, and Part D prescription drug coverage as well as additional services covered by **Medicaid**, including: Hospital, Medical, Prescription drugs, Behavioral Health, Nursing Home, Aged & Disabled (A&D) Waiver, Personal Care Services, Targeted Service Coordination, Community Based Rehabilitation Service as well as Care Coordination *Developmental Disability Services, Medical Transportation and Dental are all available through Idaho Medicaid	Idaho Medicaid Plus covers all medically necessary **Medicaid** benefits including: ▪ Hospital costs after Medicare payment ▪ Medical costs after Medicare payment ▪ Behavioral Health, including Community-Based Rehabilitation Services ▪ Nursing Home after Medicare payment ▪ Aged & Disabled (A&D) Waiver ▪ Personal Care Services ▪ Care Specialist

The MMCP also offers ***additional services over and above*** original Medicare/Medicaid such as:

BLUE CROSS OF IDAHO	MOLINA HEALTHCARE OF IDAHO
Care Coordinators – each participant is assigned a Care Coordinator to serve as YOUR advocate and central point of contact **Nurse Advice Line** – Call a Nurse 24/7 to discuss any concerns you may have related to your healthcare **Gym Membership** and at home fitness kits. $50.00 annual membership fee required **Vision** – one eye exam and $100.00 toward eyewear	**Care Coordinators** - each participant is assigned a Care Coordinator to serve as YOUR advocate and central point of contact **Nurse Advice Line** – Call a Nurse 24/7 to discuss any concerns you may have related to your healthcare **Gym Membership** and at home fitness kits **Vision** – 1 eye exam each year and $100.00 toward eyewear **Non-Emergent Transportation Services** – 22 visits per year to plan approved locations **Nutrition Counseling** – Individual telephonic nutrition counseling sessions, 30-60 minutes in length **Over the counter medications and products** - $60.00 per quarter on mail-order covered products and services **Podiatry** – 6 visits per year (in addition to the Medicare benefit) **Transitional Meal Services** – up to four (4) weeks of meals, 2 per day for post-inpatient stay or a chronic condition

Do both programs have Care Coordination?

A Care Coordinator serves as the participant's central point of contact. Care Coordination ensures a participant receives the right care and information, while working directly with the participant and/or family and healthcare provider. The MMCP program offers Care Coordinators. These are individuals that live within your communities. The Care Coordinators are available to come to your home and available by telephone. Idaho Medicaid Plus will offer Care Specialists. That means that members will have a single point of contact to serve as their advocate to help them navigate their Medicaid services. The Care Specialists will be available by telephone to the member.

Is enrollment into the programs mandatory?

Enrollment into the MMCP is always voluntary. Dual's may enroll into the MMCP with either **Molina Healthcare of Idaho** or **Blue Cross of Idaho** at any time and the effective date will always be the first day of the next month.

Beginning in October 2018 the Idaho Medicaid Plus will be mandatory for Idaho Duals that live in Twin Falls County *and* have not enrolled in the Idaho Medicare Medicaid Coordinated Plan (MMCP). Other counties will become part of the plan in 2019 after successful implementation in Twin Falls County. There are some groups of people who are excluded from mandatory enrollment, including Tribal members, pregnant women, and individuals on the Adult Developmental Disabilities Waiver program.

Does this mean I am losing Idaho Medicaid?

Absolutely not! What this means is that as a Dual your Medicaid services will be managed by a health insurance company (Blue Cross of Idaho or Molina Healthcare of Idaho.) You will receive an insurance card from the health plan as well as all other enrollee materials. Some Medicaid services will remain "carved-out," meaning they will still be covered the way they are today. Your medical transportation services will still be administered by MTM and your dental benefits will be administered by MCNA.

Do I get to choose which Health Plan I want to enroll with?

YES! Idaho Duals will have the opportunity to select either Molina Healthcare of Idaho or Blue Cross of Idaho for their Idaho Medicaid Plus plan. After the initial enrollment period there will be an Annual Open Enrollment in which Duals can change plans if they would like to.

If you select the MMCP you also can select which plan you would like to enroll with and you can also change plans at any time.

What if I don't want to enroll in Idaho Medicaid Plus?

All Duals will be required to enroll in Idaho Medicaid Plus unless they are already enrolled in the Medicare Medicaid Coordinated Plan.

Can I enroll in the MMCP today, or do I have to wait to be enrolled in Idaho Medicaid Plus?

You can enroll in the MMCP at any time! Simply call the health plan of your choice and they can take your application over the phone, it's that easy!

Blue Cross of Idaho	888-495-2583
Molina Healthcare of Idaho	866-403-8293

If you are a member of the MMCP you will not be required to enroll in the Idaho Medicaid Plus program.

Who can I talk to about programs for Dual Eligibles?

Please email IdahoMMCP@dhw.idaho.gov and we are happy to answer your questions or you can stay up to date by visiting our website @ www.MMCP.dhw.idaho.gov.